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No. 94-1178

In The

Supreme Court of the United States

October Term, 1994

EQUICOR, INC.,

Petitioner,

v.

LORDMANN ENTERPRISES, INC.,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Does ERISA preempt all state law tort claims brought by health care providers against an ERISA plan administrator for torts committed in the course of performing its duties, where the health care provider is neither a participant nor beneficiary of an ERISA plan and thus is not entitled to sue under ERISA for the injuries it has suffered?

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STATEMENT OF THE CASE

Respondent Lordmann Enterprises, Inc. (hereinafter "Lordmann") is a provider of pediatric home nursing services. Lordmann provided home nursing services to Victoria Mitchell, the infant daughter of Paula Rebecca Mitchell. Victoria was born with severe birth defects which required extensive hospitalization for the first four months of her life. When Victoria was finally discharged

from the hospital on July 30, 1990, she required home nursing care for 12 hours a day, seven days per week. Lordmann provided this care from July 30, 1990 until January 4, 1991. Without such care, Victoria Mitchell would in all likelihood have died as a result of her severe cardiovascular, gastrointestinal, and other birth defects.

Rebecca Mitchell and Victoria were eligible participants in an employee benefit plan sponsored by Hi Fi Buys, Inc., Mrs. Mitchell's employer. Under the terms of the plan, Mrs. Mitchell and Victoria were entitled to health care benefits provided by a group insurance policy issued by First Equicor Life Insurance Company. Petitioner Equicor, Inc. (hereinafter "Equicor") administered benefits and payments under the plan.

Victoria Mitchell's case was referred to Lordmann Enterprises, Inc. in July 1990, shortly before Victoria's discharge from Grady Hospital in Atlanta, Georgia. Before Lordmann began providing any services for Victoria, Lordmann's President, Susan Marot, contacted Equicor's case management office in Brea, California, to confirm the existence of insurance coverage.[1] The case marager, Geri Castagno, confirmed that the insurance policy covered 80% of the cost of Lordmann's services for 12 hours a day. Approximately one week later, the case

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[1] Equicor's Brief and the Eleventh Circuit's opinion both state that Lordmann Enterprises first contacted Equicor, Inc. *after* it began providing services to Victoria Mitchell. Equicor's Brief, at p. 5; *Lordmann Enterprises v. Equicor, Inc.*, 32 F.3d 1529, 1530 (11th Cir. 1994). However, the Affidavit of Susan Marot, which was cited by the Eleventh Circuit in its opinion, clearly states that she contacted Equicor *before* Lordmann began providing any services to Victoria Mitchell.

manager approved Lordmann's hourly rate of $50 per hour. Equicor did not disclose at that time the existence of any 30 day limit on coverage.

Based upon the representations of Equicor's case manager concerning the existence of coverage, Lordmann began providing home nursing services to Victoria Mitchell for 12 hours a day, seven days per week, commencing on July 30, 1990. Equicor's case manager continuously monitored the services being provided by Lordmann. On October 31, 1990, Lordmann's President updated Ms. Castagno concerning Victoria's condition and treatment and reconfirmed the existence of coverage under the policy for Lordmann's services. At that time, Ms. Castagno advised Lordmann's President that she could not find any provision in the plan limiting reimbursement for Lordmann's services to 80%. Ms. Castagno further advised Lordmann's President that case management had the authority to alter the plan and that she would arrange for coverage for Lordmann's services at the rate of 100 percent.

On December 11, 1990, Geri Castagno telephoned Lordmann's President and for the first time advised her that there was a question about coverage, but she would not elaborate. Lordmann's President asked Ms. Castagno whether Lordmann should discontinue its nursing services in light of the question about coverage. Ms. Castagno advised Lordmann's President not to discontinue nursing and again told her that case management had the authority to alter the plan and that Lordmann's services would be covered at the rate of 100 percent. Later that same day, Ms. Castagno telephoned Lordmann's President again and told her that Rebecca Mitchell had not

returned a case management form that Ms. Castagno had sent to her. Lordmann's President asked Ms. Castagno to fax the form to her so that she could have Mrs. Mitchell sign it, but Ms. Castagno refused to do that. Lordmann's President again asked whether Lordmann should discontinue its nursing services to Victoria Mitchell, and Ms. Castagno again told her not to discontinue treatment. Ms. Castagno at that time advised Lordmann's President that another insurance carrier was involved and that Lordmann would be paid 100 percent by one or the other of the carriers.

Lordmann provided home nursing care to Victoria Mitchell for 12 hours a day, seven days per week, until January 4, 1991, based upon the representations and assurances of Equicor's representatives. Throughout this period, Equicor monitored the treatment of Victoria Mitchell and was fully aware of the treatment being provided by Lordmann based upon its representations. However, Equicor subsequently refused to pay for the services it had induced Lordmann to provide. Relying upon language in the plan which limited coverage for home nursing care to 30 days in a calendar year, Equicor ultimately paid Lordmann for 80 percent of the cost of its services for 30 days during 1994 and for the four days during 1995, leaving a balance of almost $60,000.

Lordmann subsequently brought suit in the Superior Court of Fulton County, Georgia, asserting claims for fraud and negligent misrepresentation under Georgia law. These claims were asserted by Lordmann in its own capacity and not as an assignee of any rights of Victoria or Rebecca Mitchell. Equicor removed the case to the United States District Court for the Northern District of

Georgia, alleging as the basis for removal federal question jurisdiction and diversity jurisdiction. Lordmann subsequently amended its Complaint to assert two claims as assignee of Rebecca Mitchell's benefits under the plan.

The District Court subsequently granted summary judgment in favor of Equicor as to all four of Lordmann's claims. The District Court held that Lordmann's state law claims were preempted by ERISA, even though Lordmann was neither a participant nor a beneficiary under the plan. As to Lordmann's ERISA claims, the District Court held that the plan limited Equicor's liability for home nursing coverage to 80% of 30 days in a given calendar year and that Equicor was not estopped from contending otherwise. It held that this limitation was binding upon Lordmann, even though Lordmann had never even seen the plan and had relied entirely upon Equicor's representations concerning the amount of coverage.

The Eleventh Circuit Court of Appeals affirmed the District Court's grant of summary judgment as to Lordmann's fraud[2] and ERISA claims. However, the Eleventh

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[2] The Eleventh Circuit held that Lordmann's fraud claim was defective because there was insufficient evidence in the record to establish scienter, an essential element of a fraud claim under Georgia law. The Eleventh Circuit reached this conclusion even though Equicor's motion for summary judgment in the trial court had been based entirely upon the argument that the claim was preempted by ERISA. Since Equicor's argument in the District Court had not attacked the sufficiency of the evidence to support the claim but had addressed only the issue of whether the claim was preempted by federal law, Lordmann's response to the motion made no attempt to offer evidence as to

Circuit held that the Lordmann's claim for negligent misrepresentation under Georgia law was not preempted by ERISA. It is this ruling of the Eleventh Circuit which Equicor asks this Court to review.

SUMMARY OF THE ARGUMENT

This Court should not grant the writ of certiorari. The decision of the court below is consistent with the decisions of every circuit except the Sixth Circuit. The Sixth Circuit's decision in *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (6th Cir. 1991), which was a split decision with a vigorous dissent, is an anomaly which will remain unfollowed. Moreover, now that this Court

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each element of the claim. The District Court's grant of summary judgment as to the fraud claim was based entirely upon preemption grounds, as the Eleventh Circuit itself recognized. 32 F.3d at 1532, n. 2. The issue as to the sufficiency of the evidence to support the fraud claim was raised by Equicor for the first time in the Eleventh Circuit Court of Appeals. Even though it declined to consider the merits of the negligent misrepresentation claim since it had not been addressed by the trial court, and even though there was no reason for Lordmann to have introduced evidence to support each essential element of its fraud claim in the District Court, given the nature of the motion for summary judgment, the Eleventh Circuit agreed with Equicor's argument and held that there was insufficient evidence to support the fraud claim. *Id.* at p. 1532. The Eleventh Circuit reached this result even though there was ample circumstantial evidence from which a jury could have found intent to deceive Lordmann, including evidence that at the time Equicor was encouraging Lordmann to continue providing services on December 11, 1990, it had already decided not to pay for such services.

has clarified the meaning of the words "relate to" in Section 514(a) of ERISA, and given the growing number of federal circuit courts which have held that health care providers' state law claims are not preempted by ERISA, the Sixth Circuit will undoubtedly reconsider its decision. There is no need for any further guidance from this Court.

ARGUMENT IN OPPOSITION TO GRANTING OF WRIT OF CERTIORARI

A. THE APPARENT CONFLICT IN THE CIRCUITS CAN BE RESOLVED WITHOUT A RULING BY THIS COURT IN THIS CASE

Equicor asks this Court to review the Eleventh Circuit's holding that ERISA does not preempt a state law tort claim brought against an ERISA plan administrator by a third party health care provider who is neither a participant nor a beneficiary of an ERISA plan. Every circuit court which has addressed the issue, except the Sixth Circuit, has agreed that ERISA does not preempt such claims. *See The Meadows v. Employers Health Insurance*, 47 F.3d 1006 (9th Cir. 1995); *Hospice of Metro Denver, Inc. v. Group Health Ins. of Oklahoma, Inc.*, 944 F.2d 752 (10th Cir. 1991); *Memorial Hospital System v. Northbrook Life Insurance Co.*, 904 F.2d 236 (5th Cir, 1990). Those circuits, like the Eleventh Circuit in the case below, have recognized that preemption of claims such as those asserted by Lordmann below would defeat rather than promote the purposes of Congress in enacting ERISA. *Memorial Hospital System v. Northbrook Life Insurance Co.*,

904 F.2d 236, 245-247 (5th Cir. 1990). As this Court has previously noted, Congress enacted ERISA to protect the interests of employees and beneficiaries covered by benefit plans. *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 113, 109 S. Ct. 948, 955, 103 L.Ed.2d 80 (1989). The Fifth, Ninth, Tenth and Eleventh Circuits have all recognized that entities which are neither participants nor beneficiaries of an ERISA plan are outside the "closely integrated regulatory system" Congress enacted to "promote the interests of employees and their beneficiaries in employee benefit plans". *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S. Ct. 478, 112 L.Ed.2d 474 (1990). *See, e.g. Memorial Hospital*, 904 F.2d at 249 (5th Cir. 1990). These Courts have also recognized the commercial reality that third-party health care providers must be able to rely upon representations concerning coverage made by a plan administrator. *Memorial Hospital*, 904 F.2d at 247-248. If health care providers are unable to rely upon the representations concerning coverage made by the plan administrator, they will be forced either to deny care or to raise fees to protect themselves against the risk of non-coverage. *Id.* In either event, the employees whom Congress sought to protect would find medical treatment more difficult to obtain. *Memorial Hospital*, 904 F.2d at 246; *The Meadows v. Employee Health Insurance*, 47 F.3d at 1011.

The only Circuit Court which has held that state law claims brought by health care providers were preempted by ERISA has been the Sixth Circuit. *See Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d. 1272 (6th Cir. 1991). In that case, the Sixth Circuit, relying upon this Court's decisions in *Metropolitan Life Insurance Co. v. Mass.*, 471 U.S. 724, 730, 732-733, 105 S. Ct. 2380, 2385-86, 85 L.Ed.2d

728 (1985), and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 103 S. Ct. 2890, 77 L.Ed.2d 490 (1983) held that the health care provider's state law claims were preempted by Section 1144(a) of ERISA because they "related to" an ERISA plan. In *Metropolitan Life* and *Shaw*, neither of which involved claims asserted by health care providers who were not participants or beneficiaries of a plan, this Court indicated that the words "relate to" in Section 1144(a) should be given a broad and expansive meaning because Congress intended to preempt the entire field of administration and enforcement of employee benefit plans. Using a literalist approach, the Sixth Circuit held that the health care provider's tort claims "related to" an ERISA plan because the conduct at issue had occurred as part of the plan administrator performing its duties under the plan and because it perceived the claim as, in essence, a claim for recovery of an ERISA plan benefit. *Cromwell v. Equicor-Equitable HCA Corp.*, 944 F.2d 1272 (6th Cir. 1991).[3] The Sixth Circuit held that the health care provider's state law claim was preempted by ERISA even though the health care provider would be left without any remedy whatsoever. The Sixth Circuit gave no consideration whatsoever to whether such a result would harm the very people Congress sought to protect when it enacted ERISA. The Sixth Circuit also gave no consideration to the fact that the health care provider was not a participant or beneficiary of the plan.

Even though there is an apparent conflict in the circuits concerning whether a third party health care

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[3] Lordmann's state law tort claim sought tort damages from Equicor, rather than benefits under the plan.

provider's state law claims against an ERISA plan administrator are preempted by ERISA, there is no reason for this Court to grant a writ of Certiorari in this case. The only circuit to hold that such claims are preempted by Section 1144(a) has been the Sixth Circuit, and its decision was based, in large part, on this Court's opinion in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983). In *Shaw*, this Court stated that "a law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan", 463 U.S. at 96-97, although the Court did note that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." 463 U.S. at 101, n. 21. The Sixth Circuit in *Cromwell* read this to mean that if a state law claim had any connection whatsoever with an employee benefit plan it would be preempted. However, this Court has recently revisted its interpretation of those words. In *New York State Conference of Blue Cross & Blue Shield Plans, et al., v. Travelers Insurance Company*, ___ U.S. ___, 113 S. Ct. 1671 (1995), this Court narrowed its earlier interpretation of the scope of ERISA's preemption of state law. The Court noted

> If "relate to" were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course, for "[r]eally, universally, relations stop nowhere." But that, of course, would be to read Congress's words of limitation as mere sham, and to read the presumption against pre-emption out of the law whenever Congress speaks to the matter with generality. That said, we have to recognize that our prior attempt to

> construe the phrase "relate to" does not give us much help drawing the line here. . . . [H]ere an uncritical literalism is no more help than in trying to construe "relate to." For the same reasons that infinite relations cannot be the measure of pre-emption, neither can infinite connections. We simply must go beyond the unhelpful text and the frustrating difficulty of defining its key term and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.

___ U.S. at ___, 113 S. Ct. at 1671 (1995).

Although the *Blue Cross* case did not involve tort claims brought by a third party health care provider, its practical non-literalistic analysis of the term "relate to" should be helpful to the Sixth Circuit and lead it to reconsider its decision in *Cromwell*, especially in light of the unanimous decisions by the other circuits.[4] Since the conflict in the circuits can be resolved by reference to

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[4] Although the Sixth Circuit has not had another opportunity to review the issue of whether a third party health care provider's state law claims are preempted by ERISA, there is some indication that the Sixth Circuit is uncomfortable with the *Cromwell* decision and is already considering revisiting the issue when it comes before it again. In *Alexander v. Electronic Data Systems Corp.*, 13 F.2d 940 (6th Cir. 1994), the Court observed that the decision in Cromwell was split three ways, with the "majority" opinion being written by a Senior District Judge, and a separate opinion, concurring only in the result, being written by Judge Surheinrich. 13 F.2d at 946. The Sixth Circuit observed in *Alexander* that both the concurring opinion and the dissenting opinion in *Cromwell* had "held that the district court must 'make a separate inquiry at the outset to determine whether the plaintiff is a "participant" . . . within the meaning of ERISA, before it turns to the issue of preemption.' " *Id.*

existing precedent, there is no need for the Court to consider this case to resolve the conflict.

B. THE DECISION OF THE COURT BELOW WAS CORRECT.

If this Court does grant certiorari, it should summarily affirm the Eleventh Circuit's decision, as that decision is the proper result and is consistent with this Court's precedent. ERISA does not preempt a healthcare provider's state-law claims for several reasons, including the following:

1. A state-law claim may, literally speaking, "relate to" an ERISA plan and yet not be preempted by ERISA. *New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Co.*, ___ U.S. ___ (1995). For example, according to this Court, (i) ERISA does not bar an employee's creditor from garnishing (under state law) an employee's benefits under an ERISA-covered welfare benefit plan, even if the garnishment suit subjects the plan to substantial administrative costs, and (ii) neither does ERISA bar suits against an ERISA plan (under state law) for run-of-the-mill claims such as unpaid rent or other debts or even torts committed by the plan's agents. *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 108 S. Ct. 2182, 100 L.Ed.2d 836 (1988). To determine whether a state-law claim "relates to" an ERISA-covered plan in a way requiring preemption, a court must consider ERISA's *scope* and *purposes*.

2. ERISA deals primarily with the rights and obligations of the employer, the plan's insurer (and the plan's administrator and any other fiduciaries), and the plan's

beneficiaries *as among themselves*. ERISA does not determine the obligations of these parties to *outsiders* such as healthcare providers. Put another way, ERISA strikes a bargain: it takes away certain rights that the employer, insurer, and beneficiaries would have against each other under state law and in lieu of these rights it provides other rights. Outsiders such as healthcare providers are not parties to this bargain. ERISA neither takes away their rights under state law nor gives them any new rights. ERISA does not address their rights at all. In short, healthcare providers are *beyond ERISA's scope*.[5]

3. Congress enacted ERISA to protect the interests of the plan's beneficiaries. If ERISA barred healthcare providers from pursuing their state-law remedies for inaccurate information about coverage, this purpose would be defeated because *beneficiaries of employer-sponsored plans would find medical care more difficult to obtain*. If providers could not rely on insurers' statements about patients' coverage under employer-sponsored health insurance policies, then providers would need to insist that such patients pay in advance or provide some other form of protection, such as evidence of ability to pay or a guarantee of payment from some third party. Alternatively, to offset the increased risk of nonpayment, providers would need to raise their fees.

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[5] The Sixth Circuit has recently acknowledged that, in determining whether a claim is preempted, a primary factor to consider is whether the claim will affect relations among the principal ERISA entities (employer, plan fiduciaries, and beneficiaries). *Van Camp v. AT&T Information Systems*, 963 F.2d 119, 123 (6th Cir. 1992).

4. Preempting healthcare providers' state-law remedies would ignore *commercial realities*. Healthcare providers are not in the business of verifying insurance coverage. Their business is caring for and treating patients. By contrast, insurers are in the business of verifying coverage, and they have in their files the applications, policies, coverage limits, claims histories, and other information needed to do it. Moreover, insurers routinely provide such verification and are aware that providers rely on it. In light of these commercial realities, it is appropriate that insurers be held accountable if their verifications are inaccurate.

5. Finally, federal preemption would override the *states' traditional authority* to resolve business disputes and allocate business risks between commercial entities. Given that such matters have traditionally been matters of state law, the courts should require clear evidence that Congress intended for such state laws to be overridden.

An insurer may argue that permitting healthcare providers to assert state-law claims for negligent misrepresentation, fraud, etc. will subject plan fiduciaries to inconsistent or conflicting regulation under the laws of different states, thereby thwarting ERISA's purpose of establishing a uniform body of law. However, ERISA seeks to establish a uniform body of law only for the purpose of regulating the principal ERISA entities (employer, insurer and other fiduciaries, and beneficiaries) in their dealings with each other. For example, ERISA seeks to impose uniform rules for determining eligibility, reviewing and paying claims for benefits, keeping records, disclosing information to participants, and filing reports with governmental agencies. State laws

regulating *these* matters would conflict with ERISA. State laws concerning misrepresentations to service providers, however, do *not* conflict with ERISA, because such state laws regulate dealings with outsiders, which are beyond ERISA's scope.

Moreover, uniformity is not ERISA's only goal. Congress enacted ERISA also to protect the interests of the plan's beneficiaries, and, as explained above, this purpose would be defeated if healthcare providers' claims were preempted.

An insurer may also argue that if state-law claims for misrepresentation are not preempted, insurers for ERISA-covered plans will stop providing coverage information to healthcare providers. However, insurers routinely provide coverage information to healthcare providers in cases of *non*-ERISA-covered insurance policies, despite the risk of liability under state law if the information is false. Insurers do this for rational business reasons. If an insurer refused to provide such information, providers would insist that patients pay in advance or provide evidence of ability to pay, a third-party guarantee, etc. or would charge higher rates to patients covered under that insurer's policies (to cover the increased risk of nonpayment) – which, in turn, would induce the insurer's policyholders to switch to another insurer. These business reasons will induce insurers to continue to provide coverage verification in the case of ERISA-covered insurance policies, as well.

It may also be argued that healthcare providers should simply obtain an assignment of the patient's rights under the plan and review the plan document for

themselves. However, ERISA-covered insurance plans do not always permit such assignments.[6] Even if all ERISA plans did permit such assignments – and even if it were practicable for healthcare providers to review each patient's insurance policy – healthcare providers could not determine coverage merely by reviewing the plan document. Coverage depends on a number of factors outside the plan document, such as the patient's status as an eligible employee or dependent, whether the patient's condition is a pre-existing condition, whether previous claims have exceeded the policy's limits, and so on. A healthcare provider cannot determine such matters without inordinate expense, which would have to be passed on to patients. An insurer can, and routinely does, as part of its business, and is in a position to be much more efficient at doing so.

Non-preemption of a healthcare provider's claims is consistent with this Court's previous decisions. *See New York State Conference of Blue Cross & Blue Shield Plans, et al. v. Travelers Insurance Co.*, ___ U.S. ___ (1995) (rejecting a literalistic interpretation of "relate to"); *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988) (ERISA does not bar an employee's creditor from garnishing an employee's benefits under an ERISA-covered welfare benefit plan, even if the garnishment suit subjects the plan to substantial administrative costs; neither does ERISA bar suits against an ERISA plan for run-of-the-mill claims such as unpaid rent or other debts or even torts

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[6] In such cases, under Equicor's analysis, a healthcare provider would have no remedy whatsoever except, perhaps, against the plan participant.

committed by the plan's agents). This Court has also indicated that the converse holds true – i.e., that ERISA does not bar a plan fiduciary from suing a third-party service provider under state law. *Mertens v. Hewitt Associates*, ___ U.S. ___, 113 S. Ct. 2063, 2067-2068, 124 L.Ed.2d 161 (1993) (Court suggested that if given the chance, it would hold that nonfiduciaries – e.g., third-party service providers – cannot be sued under ERISA for any sort of relief, whether in the form of money damages or otherwise, such suits being left to state law).

Cases where this Court has held that ERISA does preempt a claim [such as *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990)] have all involved claims between the principal ERISA entities (employer, plan fiduciaries, and plan beneficiaries). This Court has never held that ERISA preempts state law claims asserted by entities who are neither participants, beneficiaries, nor fiduciaries under an ERISA plan.

CONCLUSION

For all of the foregoing reasons, Lordmann respectfully requests that the Court deny the Petition for a Writ of Certiorari. In the alternative, Lordmann respectfully requests that the Court summarily affirm the decision of the court below.

Respectfully submitted, this 1st day of June, 1995.

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